STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152631	A. BUILDING _____ B. WING _____	01/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRESENIUS MEDICAL CARE HOBART	**1330 S WISCONSIN ST HOBART, IN 46342**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS This visit was a End Stage Renal Disease Facility federal recertification survey Survey Dates: January 11-12, 2012 Facility Number: 011693 Provider Number: 152631 Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor Facility Census In-center Hemodialysis: 40 Home Hemodialysis: 0 Peritoneal Dialysis: 0 Total: 40 Fresenius Medical Care Hobart was found to be in compliance with the Conditions for Coverage for End Stage Renal Disease Facilities 42 CFR Part 494. Quality Review: Joyce Elder, MSN, BSN, RN January 13, 2012	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.